

Did you know!

AOG (Aaa Ooo Gee)
in Hindi, Urdu &
Punjabi means...
Welcome!

towards the greater good

CONNECT

The AOG Journal

10/11

Don't Miss! Clinical Innovations

Conference and Dinner
6th-7th May 2011

President's Message

Towards the greater good!
Join the AOG

AOG BBQ Photos

Over 300 enjoy the fun!
Next BBQ in July 2011

AOG Charity Ball Photos

Over £10k raised in 15 mins!
Next Ball 4th Dec 2010

Magazine Contributors

Raj RajaRayan OBE, Rashmi Patel MBE,
Manny Vasant MBE, Bhavna & Rahul Doshi,
Arun Mehra, Sanjeev Bhanderi, Krishan Joshi
and many more.



AOG Travels to one of its Charitable Projects

Situated in the middle of India, through nowhere land, is the AOG-supported dental project in Chitrakoot. AOG helps to finance services and sends out volunteers to some 500 remote villages, sorting out pain, infections, repairing cleft palates, burns and a myriad of other oro-facial problems. Since the AOG has been funding most of these dental surgeries and supporting outreach treatments, more than 31,000 patients have been seen in-house, and a very large number treated in mobile open air treatment centres in the rural villages. Correcting clefts, diagnosing cancer, and repairing burns completely changes people's lives, livelihoods and marriage prospects. Dentistry and dentists can make a huge difference.



The AOG will fly out in February next year – during Mid-Term, when the ICC Twenty-Twenty world cup tournament is being held in India to finance a further set of projects to support the dental services. A laboratory and a surgery for a resident Clinical Dental Technician is envisaged.

Pomi Datta, the President of the AOG stated, 'I am delighted to have helped design the surgeries. They are practical and professional. I pay particular tribute to Naresh Sharma who has headed the project and the numerous other luminaries, including Crawford Grey, David Hutchinson, Oliver Fenton, Ashok Sethi, Bill Sharpling, Subhir Banerjee, Trevor Ferguson and so on, who have all been seminal in making this project come to life.'

The centre is so highly rated that a previous

Prime Minister, as well as the President of India have visited it. Virgin Atlantic also topped up the funds to support the project.

If you wish to join the AOG on tour to visit one of its charitable causes, this time in India, along with your choice of cultural highlights, from the exotic and erotic, to the ecclesiastical and the enigmatic, with a bit of golden beaches or bat on ball thrown in for good measure, then contact the AOG travel agent, Rachna of Welcome Travel to book yourself a place. Trips can be customised as the tour operators for the AOG are always flexible. The telephone number is 020 7788 6452 or visit the AOG website at: www.aoguk.org

Membership of the AOG is only £10.00. To become a member, log onto: www.aoguk.org The cost of the primary tour, including the conference in Delhi and the visit to the dental centre in Chitrakoot (or remain for a cultural extravaganza in Khajuraho till the dental party gets back) – between the 18th of February to 26th February is only £1099 per person sharing, and includes most meals as well as an invitation to three fabulous

parties. There is a joint conference in Delhi with the Indian Dental Association and the FGDP(UK).

The Chairman of the AOG Trust is Raj RajaRayan OBE and its Board includes names such as Amarjit Khambay, Rashmi Patel MBE, Mahesh Patel, Ruby Austin MBE and Manny Vasant MBE. AOG means 'welcome' in several Indian languages. Any health care worker with an interest in 'the greater good' (the AOG motto) is always welcome to join.

STOP PRESS:

Sorry! tickets for the 2010 AOG Ball on the 4th of December are now fully sold out. But bookings are being taken for its Clinical Innovations Conference at the Royal College of Physicians (May 6th & 7th 2011), the AOG Family day on Sunday 10th July and the 2011 Charity Ball on Saturday 10th December. Visit : www.aoguk.org to book yourself a place.





Presidents Message



AOG BOARD OF TRUSTEES

- Dr RajaRayan OBE
- Dr Manny Vasant MBE
- Dr Ruby Austin MBE
- Dr Rashmi Patel MBE
- Dr Amarjit Khambay - *Founder of the AOG*
- Dr Pomi Datta - *President of the AOG*

AOG COMMITTEE

- Dr Pomi Datta - *President of the AOG*
- Dr Nadeem Zafar - *Past President*
- Dr Mahesh Patel - *Treasurer*
- Dr Nishan Dixit - *Secretary*
- Dr Sanjiv Chotai - *Membership Secretary*
- Dr Suresh (Billy) Sharma - *Social Secretary*
- Dr Saif Najefi - *Social Secretary*
- Mr Krishan Joshi - *Marketing Secretary*
- Dr Parvin Amiji - *Co-opted Member*
- Dr Dinesh Jani - *Co-opted Member*
- Dr Abhay Soneji - *Co-opted Member*

CONTACT DETAILS

AOG

Sterling House
89 South Road
Southall
Middlesex UB1 1SQ

For General Enquiries

info@aoguk.org

AOG Connect Newsletter

Krishan Joshi
AOG Editor & Marketing Secretary

Internet Marketing Director
Dental Focus Web Design
T: 020 7183 8388
E: info@dentalfocus.com
W: www.dentalfocus.com

Dear Colleagues

Greed has become the byword that has marked the first decade of this millennium. You only have to look at your pension pots, our chosen private sector, to realise how greed has robbed you.

Look at our MP, our elected leadership, and you see the face of greed.

Count the payouts to public service CEO's, our appointed gatekeepers, and you can feel the grandiose nature of the greed.

View public entertainment, our window to our children, — 'greed' is the new reality show.

Not for the AOG.

'The Greater Good' is the AOG mantra for this millennium.

There are only two 'goods' in the world.

Ones personal good and the greater good.

The two paths do not make a comfortable crossing.

The AOG, which was once about 'Perfect Practice' now changes direction.

Healthcare is no longer about excellence in ones clinical practice ability. It is about contributing to the well being of a patient's life experience.

It is not about 'self' but about 'service'.

No more will the AOG support courses from one night wonders across the puddle about pretty fixes.

No longer will the AOG be about the non-science of golden proportions or bo-toxicity's.

It will be about making lives better.

The dental community has done well in the recent years.

It is time to put more than a little back into the world.

If you believe in the magic of the 'greater good,' then lets conjure up a difference.

We have reset our sights.

Which side do you want to be on?

A small donation is all it takes. Draws good water, repairs clefts and relieves pain. This all improves quality of life for so many — and it needs so few to do it.

More importantly it helps build communities.

Our current AOG project with Smile-on is the Clinical Innovation Conference. Gain knowledge, and make or renew friendships whilst enjoying the Charity Ball . All this and in support of a great cause.

Keep in touch with our future issues regarding our projects and our missions.

In order to lead by example ,we have now reduced the annual membership fee to just £10 for all Dentists and their teams registered with the GDC.

Join us for the 'greater good'. Money and muscle both welcomed with outstretched arms. After all, that is what 'AOG' (Aaa Ooo Gee) means in Hindi/Urdu/Punjabi – welcome.

Best wishes

Dr Pomi Datta

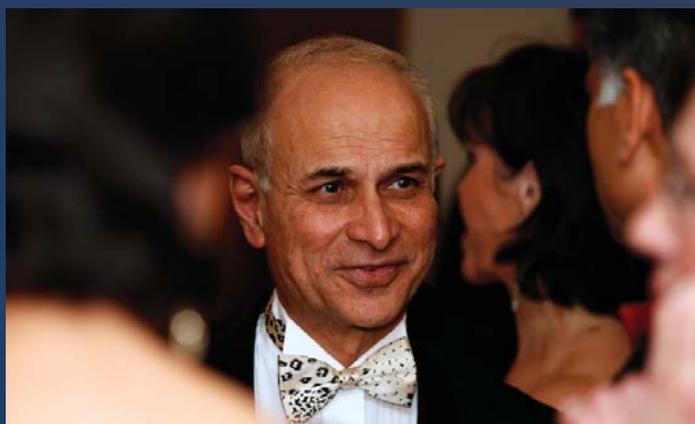
Contents

4-5	Summer BBQ	21-23	Failure of Endodontic Treatment
6-9	Charity Ball	24	Intruding anterior teeth in adults
10-11	Achievements in Dentistry	26-27	Clearstep
12	Chitrakoot Project	28-29	Periodontal Disease
13	Walks for Musoma	30	The Private Squat Practice
14	Kenya & Tanzania	31	How to improve your website
16-17	Mouth Cancer Walk	32-33	A Successful Profitable Practice
18-20	Tooth Erosion		



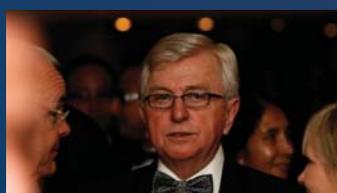
AOG Charity Ball

£10K raised in just
15 minutes!



Every year the AOG Ball is an opportunity to work "towards the greater good" and raise funds for our chosen charities. Dr Ashok Sethi gave a very moving, personal presentation about the Chitrakoot Project - don't miss the article within our Charities section of this magazine. Prizes were raffled off at the AOG Ball by Mr Mike Volk of Dental Directory in order to raise money for this worthy cause. Over £10,000 was raised in just 15 minutes!

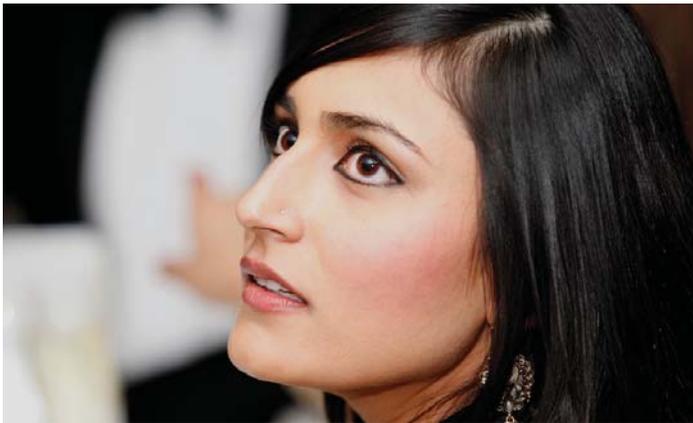
The AOG Ball is a black-tie dinner and dance event including fine Indian cuisine, entertainment and great company for networking. Limited places are available. The next ball is on Saturday 4th December 2010 at the Millennium Gloucester Hotel in London. Limited tables available. Book early to avoid disappointment - visit www.aoguk.org





AOG EVENTS





AOG Celebrates Achievements in Dentistry

An evening of celebration and reunion was held to celebrate the great achievements of senior AOG members in the dental profession and witness the inauguration ceremony of the new AOG President, Dr Pomi Datta. Those present included past and present friends and colleagues from the Royal London Dental School, Ealing PCT, EH&H LDC and the AOG, including:

- The Rt. Hon. Virendra Sharma, MP for Ealing and Southall
- Raj K Raja Rayan OBE, Associate Dean, London Deanery
- Russ Ladwa, Dean Elect, Faculty of General Dental Practice (UK)
- Amarjit Gill, BDA President 2010
- Pomi Datta, New President, AOG
- AOG Past Presidents: Ruby Austin MBE, Rashmi Patel MBE, Amarjit Khambay, Nadeem Zafar





AOG Raises over £10K for the Chitrakoot Project. A UK based charity active in Madhya Pradesh

Article written by Naresh Sethi, FCCA, Trustee www.chitrakootuk.org

THE AOG provided some start up funds towards the Chitrakoot Project over a decade ago. After an assessment of their progress and continuing needs, the AOG committee have selected The Chitrakoot Project as the beneficiary of this year's charity funds. The AOG Charity Ball raised over £10,000 within 15 minutes. These funds will help provide further support for its continuing dental projects in Madhya Pradesh (MP).



Cleft lip before & after

Our current AOG President Dr Pomi Datta together with Dr Naresh Sharma were the founding members of the Chitrakoot Project. Dr Pomi Datta performed the first dental surgery there. He also designed and planned their Chitrakoot Dental Institute, and continues to be involved in their current rural and school dental projects. He thanks the committee for its support towards a worthy cause which will benefit those in need.

Volunteers to assist with the aims of this project are welcome! He promises it to be a unique experience. Just ask those who have

been there! If you are interested in volunteering or support the Chitrakoot project then please visit www.aoguk.org or email info@aoguk.org

The Chitrakoot Project Charity is a Charity registered in England. It has 11 UK trustees and is involved in providing free (or virtually free) dental treatment to children, poor & destitute people in Chitrakoot, MP, extending to about 500 surrounding villages

The Charity also equips the dental department, recently an OPG X-ray machine was purchased and sent to Aroghyadam.

Chitrakoot is a small town of about 35,000 people located 500 miles South East of Delhi. It is on the border between Madhya Pradesh and Uttar Pradesh, two poor & deprived areas.

The Charity works in conjunction with DRI (Deendayal Reasearch Institute), a well established and respected Indian Charity; the founder of DRI is Nanaji Desmukh. DRI makes available their hospital, Aroghyadam, where our equipment is located and our dental department is based. The dental department in Aroghyadam usually has three full time dentists based there who provide year-round dental treatment to about 10,000 patients per year. The treatment varies from simple infections/ routine dental treatment to trauma & cancer. There is also a mobile clinic (a van equipped with dental equipment) that does a round of the villages regularly.

Every year there are about 30 – 50 clinicians visiting from the UK, who provide treatment from regular dental treatment

to cleft operations. In recent years we have held cleft treatment camps where more than 200 patients have been treated; this included many children with facial deformities. Two of the recent camps were largely funded by a grant of £83,000 from Virgin Atlantic.

The main people operating at the recent surgical camps were Mr Oliver Fenton & Ms Claudia Malic (consultant plastic surgeon), Dr David Hutchinson (retired consultant Oral Maxillo facial surgeon) and Dr Frank Jennings & Dr Bala (anaesthetists) and Dr Naresh Sharma & Dr Ashok Sethi (surgeons).

The Charity is Chaired by Dr Naresh Sharma who has a soft spot for the region and its people and has been involved in charitable work helping with providing basic oral surgery, etc since 1998. He is also currently vice-President of DRI. The Charity also purchases materials & equips the dental department, recently an OPG X-ray machine was purchased and sent to Aroghyadam.

The volunteer dentists who visit Chitrakoot to provide their services free also pay their own airfares – food and lodging at Aroghyadam, Chitrakoot is provided courtesy of DRI. The Charity only pays travel expenses for its nursing staff. None of the trustees claim travel expenses.

The Charity's fundraising is via regular donors, donations such as the AOG original seed funding, the recent AOG Charity Ball raffle raising over £10,000 in 15 minutes, the £83,000 grant from Virgin Atlantic, the recent donation of £10,000 from entrepreneurial business man Mr M Patel, and by fund raising events such as dinners - one earlier dinner was attended by Geoffrey Boycott (a famous Yorkshire cricketer). Another event is planned for spring 2010.



Imagine struggling through life like this

AOG Walks for Musoma

check up and over 40 received necessary treatment. The team included builders and they helped build a classroom and sewing room at LVDC.

Who/what are LVDC?

LVDC is a registered NGO specialising in vocational training, such as woodwork, dressmaking and knitting, and metal work. LVDC provides disadvantaged youths with the access to education and skills that they can use later in life and thus not only reducing dependency on their families but becoming integral members of the society. The centre is also the only provider of mobility aids in the area, an essential function in order for the disabled be independent.

Lizzie Cameron and her parents who have spent over a year in Musoma will also join us on the day (see CNN <http://edition.cnn.com/CNN/Programs/bethechange/>)

The Route

Start point Putney Bridge: Dukes Head along Thames Place (near Thai Sq Restaurant) - walk along the Embankment past Steve Fairbairn obelisk, Harrods furniture depository then under Putney Bridge, past back of St Paul's school. Keep to the river bank. At Barnes, cross over to Lonsdale Rd towards Bull's Head for a midpoint drink (50 yds after the cut in the railings). Turn left on to High St and head towards the park - cross Station Rd - bear left at the pond - bear left at sign Beverley Brook Walk - cross Rocks Lane - Raleigh path - past tennis courts - Head towards Lower Richmond Rd - past the sign V Miles from Hyde Park corner Spencer Arms will be on the right across the road situated at the junction of Lwr Richmond Rd and Putney Common. We meet at All Saints Church at the end of Putney Common for BBQ and drinks. Collect your certificates and hand in your completed forms there.

Please visit www.musoma.com website or contact Manny Vasant: mvasant@btinternet.com. For more information on LVDC please visit: www.lakevictoriadisabilitycentre.org

Where is Musoma?

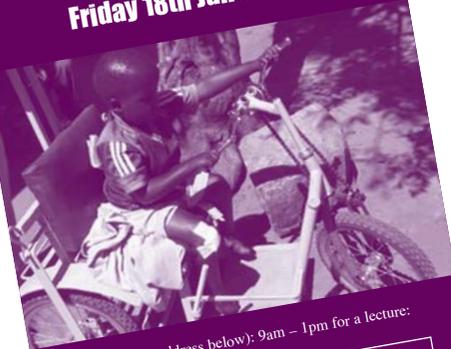
Musoma is located in the Mara region of Tanzania, East Africa. The rural communities of Mara continue to suffer from abject poverty. This is due to an absence of employment opportunities; ill health caused by malnutrition, too few schools and affordable health service. 10% of the population in this region are disabled due to diseases such as malaria, meningitis and polio.

Between 2006-2009 we have raised in total about £50,000. This money has been used to improve medical facilities, refurbish two schools, and help expand a vocational training centre for the disabled.

Sponsorship this year will help further develop Lake Victoria Disability Centre (LVDC), providing dental, ophthalmic and physiotherapy services for the disabled community of Musoma.

A team of volunteers led by Manny Vasant in 2008 enabled over 150 disabled children to have a dental

Charity Walk
Along the River Thames in aid of
Lake Victoria Disability Centre,
Musoma, Tanzania
Friday 18th June 2010



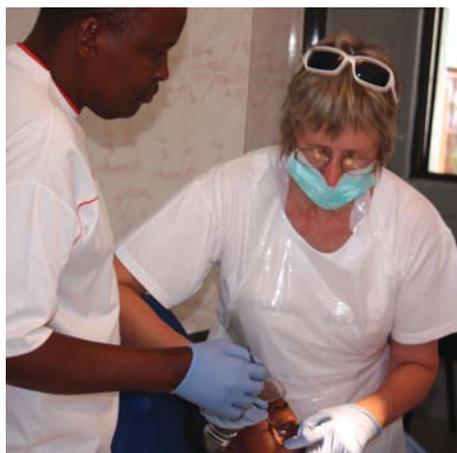
Dentists (at address below): 9am - 1pm for a lecture:

Antimicrobial Prescribing
Dr Nick Palmer

Clinical Update on tooth whitening
Mr Wyman Chan

All participants: Bites and Briefing about the projects at 1pm at
The Brewer Building, St.Mary's Church, Putney High Street,
Putney, London, SW15 1SN.

The walk will commence around 2pm at Putney Bridge after a
light lunch and finish at the Cricket Hut (in the Common)
Lower Richmond Road Putney where there will be a BBQ and
Drinks from 3pm till late.
Everyone invited.



The fund raising event is organised by Dr Manny Vasant MBE (07958 902095) and Dr Arrif Lalani (0788 6558604). Supported by trainers and vocational dental practitioners (London Deanery, University of London), Tanzania Development Trust (www.btsociety.org); British Society of General Dental Surgery (www.bsgds.com); AOG (www.aog-uk.org); Overseas Musomians (www.musoma.com). Leaflets printed by The Dental Directory. Sponsored by dental trade (trade stands and details of sponsors will be on the programme on the day). Registered Charity - Tanzania Development Trust - 270462

Kenya & Tanzania

JULY 14th - 28th 2010

Trip to Mombasa with Optional extras to National Parks (Tsavo or others) or voluntary work in Musoma, Tanzania (see below). BSGDS members and Overseas Musomians invited.

Indicative costs

Return flights
London/Nairobi - £650
Accommodation Whitesands Hotel per night (half board) – Mombasa
US \$ 70 per person sharing in a double / twin room
US \$ 70 per person in a single room
US \$ per person sharing in a triple room

The total per person would be approx £1200 for 2 weeks

Optional Extra (charity work in Musoma):
Flight to Mwanza and overland Musoma £280 plus Basic accommodation for volunteers £35-50 per night. (Day trips to Serengeti National Park are possible from Musoma).

Background

For some years now Dr Manjul (Manny) Vasant MBE has been trying to help various projects in Musoma. Funds have been raised under the aegis of Overseas Musomians (www.musoma.com); Dental Vocational Trainees (London Deanery) Charity Walk; Britain Tanzania Society, Tanzania Development Trust (www.btsociety.org); Anglo Asian Odontological Group (www.aog.com); British Society for General Dental Services (www.bsgds.com) and dental trade and practitioners in the UK. More recently we have formed partnership with Lizzie Cameron who is a volunteer at the Lake Victoria Disability Centre run by Dennis Maina (www.lakevictoriadisabilitycentre.org).

Recent activities

- Refurbishment of two schools Iringo (formerly Nanakchand); Mukendo (formerly Agakhan) and dental unit at Musoma Hospital.
- Provided Oxygen machines and other vital equipment to Musoma Hospital.
- Refurbished dental department of a Musoma Regional Hospital
- Refurbished disability centre and provision of some equipment to train vocational trainees at Lake Victoria Disability Centre (LVDC formerly Musoma Engineering).
- Provided musical instruments to three schools (one of them a blind school).

Future plans for 2010 and beyond

- We are hoping to expand the disability centre by purchasing additional land/premises so we can expand our training programme. Currently disabled people are trained for a vocation in metal work, carpentry, plumbing, sewing etc.
- We wish to include computer, catering, teaching, music and medical/dental care personnel training by encouraging volunteers to visit Musoma for a few days/weeks as convenient. In the first instance a one week optional extra trip is being proposed (first week holiday in Zanzibar)

- We are also hoping to build some accommodation for visiting volunteers.
- Train local people to provide simple dentistry such as minimally invasive GLC techniques and simple extractions (Joe Frencken's who has run programmes in Tanzania will assist)

How you can help?

1. Assist in running the programme and provide training in any skill that you can pass on.
2. Donate funds for the extension of the programme by "buying bricks @ £500 each" or any making any other donation (Funds are donated to TDT registered charity number 270462). Please e mail mvasant@btinternet.com for appropriate from or download from website www.musoma.com

NB: Volunteers are self-funded. We can organize very basic, clean and safe accommodation. 100% of the funds are used for charity. No administration or other expenses are deducted from the funds.

Register of Interest ASAP to secure the booking please to M K Vasant 1210 London Rd London SW16 4DN mvasant@btinternet.com

I/We are interested in joining the trip to Mombasa with an option to go to Musoma to help. Please send me further details

Name(s): _____

Address: _____

Telephone Work _____
Telephone Home _____
Telephone Mobile _____

Email: _____
■ I/We are interested in trip to Mombasa
■ I/We are interested in a further trip Tsavo
■ I/We are interested in a further trip Musoma for voluntary work
My/Our interest to do voluntary work are:
Teaching/Doing Basic Dentistry
Other: _____

FACIAL

Rejuvenation & Aesthetics

Facial Aesthetics and Skin Rejuvenation treatments offer your Practice an exciting and profitable new business opportunity.

Demand is growing rapidly and patients want these treatments undertaken in a clinical environment by a qualified healthcare professional. What better clinical environment than your Dental Practice?

The Dental Directory offers a complete range of the latest, specialist Facial Aesthetic and Skin Rejuvenation products, including:

- **Dermal Fillers**
- **Botulinum Toxin Type A**
- **Skin Rejuvenation**
- **Microdermabrasion**
- **Training**

Details on all these and more can be obtained from our dedicated Facial Aesthetics Sales Team. They can also help with the various accessories and sundries required, plus provide details on how you can enroll in accredited, hands-on training courses.

So whether you already offer Facial Aesthetic treatments, or are looking at starting up, our dedicated Facial Aesthetic sales team are here to help and advise.

For further information call
0800 585 586

Trust...



for Facial Aesthetics



Mouth Cancer Walk
www.mouthcancerwalk.org



Join the FREE Mouth Cancer Walk In September 2011 in Hyde Park, London

to have a fun, family day out in the sun,
raising awareness & funds!

A big thank you to over 600 people who made the 2010 Mouth Cancer Walk - the 5th Anniversary - a huge success, raising thousands of pounds for the Mouth Cancer Foundation's charity objectives.

Don't miss out next year - register online for FREE at www.mouthcancerwalk.org or visit www.mouthcancerfoundation.org for information and support.





Tooth Erosion

An increasing problem

Raj RajaRayan OBE and Rashmi Patel MBE (photographs courtesy of Manny Vasant MBE)

What would you do when a young adult visits the practice with evidence of tooth surface loss that is greater than expected?

The last Adult Dental Health Survey was concluded in 1998 – more than a decade ago¹. It reported that two thirds of adults have some non carious tooth surface loss (TSL) into dentine on their anterior teeth, whilst 11% had extensive involvement of dentine and 1% had severe wear.

Child Dental Health Survey of seventeen years ago identified that 32% of 14 year olds had evidence of erosion affecting the palatal surfaces on their permanent incisors. The Dental Health Survey of Children and Young Adults, commissioned in 2003, reported, that for England, ‘The proportion of 5-year-olds with evidence of TSL on one or more of the buccal surfaces of the primary upper incisors was 17 per cent, and 2 per cent had TSL involving dentine or pulp. TSL of the lingual surface was more common, affecting just under half (46 per cent) of 5 year olds. TSL progressing to dentine or pulp was present on 20 per cent of lingual incisal surfaces’².

Whilst TSL is a normal physiologic process that occurs throughout life with the significance of the loss attributed to age and reasonable other factors, an increase in the rate of wear challenges the viability of the tooth or is a source of concern to the patient. Pathological tooth surface loss is defined as when ‘the teeth become so worn that they do not function effectively or seriously mar appearance before they are lost through other causes or the patient dies’³. Some TSL is caused by

- attrition - produced by direct contact of occluding or proximal surfaces
- abrasion – produced by exogenous material forced over tooth surfaces
- erosion – produced by chemical dissolution of teeth by acids excluding

those produced by bacteria

- abfraction – produced by tensile forces induced by occlusal loads leading to microfractures of the cervical enamel on facial and lingual surfaces⁴.

Whilst there are several aetiological factors leading to pathological tooth surface loss, There has been an increasing trend in erosive tooth surface loss in young adults. This is similar whether in the USA or in the UK⁵. It is so important to diagnose this early as it is relatively easy to prevent the ongoing TSL of the dentition.

The patient who presented above was a young female adult. She had little concern and had no knowledge of the TSL she was undergoing. It is all too tempting for a dentist to scaremonger the patient and create an insecurity in the patient to mutilate the dentition as happens all too often. The iatrogenic tooth destruction by the professional to ‘fix’ this problem has become increasingly common with litigation, quite rightly, catching up with the profession. For those who have not already read it, I will refer you to the excellent article in ‘Guest Comment’ in the Dental Update by Martin Kelleher⁶ titled ‘The ‘Daughter Test’ in Aesthetic (‘Esthetic’) or Cosmetic Dentistry’. In it he discusses the ‘populist, if somewhat mindless programmes like ‘Extreme Makeover’ and ‘Ten Years Younger’ giving birth to the concept of ‘hyperenamelosis’ ‘an imaginary dental condition in which patients are born with too much enamel or an imagined condition in which the enamel prisms grow following tooth eruption and, if left alone and not cut back by a dental bur, would somehow grow out of control’. He goes on to say that teeth neither suffer from ‘hyperenamelosis’ nor from ‘porcelain deficiency disease’. His daughter test reads ‘Given that competing aesthetic philosophies and various bits of dental technologies exist



and, indeed, often have enthusiastic proponents, a simple test is proposed to help clinical decision-making in this difficult and complex area. This is called the ‘Daughter Test’ in Elective Aesthetic Dentistry. At its simplest, it asks the question ‘Knowing what

I know about what this procedure would involve to the teeth in the long term, would I carry out this procedure on my own daughter? It is curious that the daughters of dentists never seem to suffer from a 'porcelain deficiency disease' or hyperenamelosis'. This article is a MUST READ for all practitioners. It is worth a subscription to Dental Update just for that reason.

With regard to erosion and TSL, other than an idiopathic diagnosis⁷, acids affect the teeth from external and internal sources with the sites of erosion giving an indication of the cause⁸ as given below.

Exogenous causes of TSL

- Diet, e.g. acidic citrus fruits, fruit juices, carbonated beverages, vinegars and pickles.
- Medicines, e.g. HCl replacement, chewable ascorbic acid or acetylsalicylic acid tablets, iron tonics.
- Occupational, e.g. acid vapors, wine tasting.
- Sports, e.g. improperly chlorinated commercial pools and heated spas

Endogenous causes of TSL

1. Consequence of anatomic defects, e.g. hiatus hernia, gastroesophageal reflux disorder, esophageal diverticulosis.
2. Psychological problems, e.g. vomiting or regurgitation of gastric fluids into the mouth from bulimia nervosa, alcoholism, stress rumination.
3. Side effects of drugs, e.g. for chronic

asthma, or overuse of drugs irritating the gastric mucosa.

4. Medical conditions, e.g. uraemia, peptic ulcer, morning sickness during pregnancy.

The taste for acid tasting food develops in childhood with carbonated drinks containing organic and phosphoric acids⁹. This may evolve to drinking beers, some of which have low pH values⁷. With today's social pressures on slimming, there is an increasing consumption of low sugar acidic beverages, acid containing diet foods and many other food substances, including pickles of pH3.0 or less and other abrasive food products¹⁰.

Social pressures on teenagers in the Western society has led to binge drinking followed by involuntary regurgitation with chronic vomiting. Bulimia nervosa¹¹ and stress rumination¹² have all been documented.

So how does one manage a young adult with the classic pattern of erosive TSL due to bulimia or binge drinking with the consequence of involuntary chronic vomiting? The last thing a dentist should do is reach for the drill.

The world has changed. To quote Raj RajaRayan¹³ 'This millennium heralded major changes in attitudes and thinking in the way staff in the NHS became accountable for patient care. 'Safeguarding Patients'¹⁴ was the Government's response to the recommendations of the Shipman Inquiry's

Fifth Report¹⁵ and to the recommendations of the Ayling¹⁶, Neale¹⁷ and Kerr/Haslam¹⁸ Inquiries (the three inquiries). The question of how Shipman was able to murder so many patients without being detected as well as the issues raised in the three inquiries led to the report. The further question was raised that if systematic murder goes undetected, what protection does the patient have to systematic maltreatment in any practice environment. 'Trust me, I am a doctor' was a cliché that now needed to be earned. It is for these and other reasons that following the advice given by the Chief Medical Officer, Sir Liam Donaldson¹⁹ and the parallel review on non-medical professions by Andrew Foster²⁰ of the Department of Health, that the Government published its White Paper 'The regulation of health professionals in the 21st century – trust, assurance and safety, in February 2007.²¹

'Patients need to be protected. The diagnosis of such patients is to obtain good information. Getting reliable information on their dietary habits is notoriously inaccurate. Hence diagnosis is usually by the tooth wear patterns²² which are well documented and relate reasonably to the matching profile of the person and presenting condition²³.

Management starts with documenting the pathology. This includes high quality study casts, photographs and a contemporaneous record of the extent of the lesion, using an internationally documented tooth wear index, such as the one proposed by Smith and Knight²⁴.

David Bartlett just published a new system for screening tooth wear²⁵. The index is based on the BPE (Basic Periodontal Examination) and uses similar protocols. The tool is termed the Basic Erosive Wear Examination (BEWE). There is also a complexity level which is a guide to clinical management. It is 'designed to be simple to use, easily recorded in notes, and gives practitioners to record that the wear has been examined and considered. The criteria for grading erosive wear:

- 0 – no erosive tooth wear
- 1 – initial loss of tooth surface texture
- 2 – distinct defect, hard tissue loss <50% of the surface area
- 3 – hard tissue loss > 50% of the surface area

This new tool, if adopted in UK will become an index of treatment need and a guide with some justification to appropriate treatment for the different presenting TSL. Good record keeping is not only quite

Some erosive agents

(Linda Shaw BDA Conference, 1998)

Drink	Relative titratable acidity	pH	Erosive potential
Grapefruit Juice	9.3	3.2	High
Apple juice	4.5	3.3	High
Orange juice	4.8	3.8	High
Cola	0.7	2.5	Medium
Schweppes	2.6	2.6	Medium
Diet Cola	0.5	2.9	Medium
Carbonated orange drink	2.0	2.9	Medium
Red wine, Claret	3.3	3.4	Medium
White wine, Chardonay	2.2	2.7	Medium
Beer - Bitter	0.6	3.9	Low
Beer - Lager	0.5	4.4	Low
Sparkling water	0.1	5.3	Low

Tooth wear index

Smith & Knight 1984 (Br Dent J 156,157)

Score	Surface	Criterion
0	B/L/O/I	No Loss of Enamel Surface Characteristic
	C	No Change of Contour
1	B/L/O/I	Loss of Enamel Surface Characteristic
	C	Minimal Loss of Contour
2	B/L/O	Loss of Enamel Exposing Dentine for less than one-third of the surface
	I	Loss of Enamel just exposing Dentine
	C	Defect less than 1mm deep
3	B/L/O	Loss of Enamel exposing Dentine for more than one third of the surface
	I	Loss of Enamel and substantial loss of Dentine - not exposing pulp or secondary Dentine
	C	Defect 1 - 2 mm deep
4	B/L/O	Complete loss of Enamel or Pulp exposure or exposure of Secondary Dentine
	I	Pulp Exposure or Exposure of Secondary Dentine
	C	Defect more than 2mm deep o Pulp Exposure or Exposure of Secondary Dentine

important medico legally, but one can map the progress of the pathological condition with a degree of accuracy over a period of time. Suspicion of bulimia, alcoholism, regurgitation, amongst others, requires medical confirmation and mangement. A dentist should not become the whole health care profession, but must be considered a gatekeeper of the health care professions for the patients well being.

When it comes to undertaking dentistry, less is always more. Even if one places a glass particle based adhesive composite restoration, the effect of its high abrasivity on the opposing tooth should be balanced on the basis of gain versus loss.

Dentistry is no longer the craft of cut and fill. It is the ethical domain of professionalism balanced by the delicate science of understanding the consequences of poor diagnosis, inappropriate management, over ambitious treatment and the inability to predict the prognosis.

The profession has changed. Has the professional?

References

¹Adult Dental Health Survey: Oral Health in the United Kingdom 1998" HMSO The Stationery Office, ISBN 0 11 621268 3

²http://www.statistics.gov.uk/children/dentalhealth/downloads/cdh_England.pdf retrieved on 01.04.2010

1. ³Smith BGN, Knight JK. An index for measuring the wear of teeth. Br Dent J 1984;156:435-438.

⁴Osborne-Smith KL, Burke FJT, Wilson NHF. The aetiology of the non-carious cervical lesion. Int Dent J. 1999;49:139-143

⁵Bartlett D, Phillips K, Smith B. A difference in perspective – the North American and European interpretation of tooth wear. Int Dent J Prosthodont 1999;12:401-408

⁶Kelleher M. The 'Daughter Test' in Aesthetic ('Esthetic') or Cosmetic Dentistry; Guest Comment. Dental Update: Jan/Feb 2010

⁷Jarvinen VK, Rytomaa II, Heinonen OP. Risk factors in dental erosion. J Dent Res 1991;70:942-947

⁸Jarvinen V, Rytomaa I, Meurman JH. Location of dental erosion in a referred population. Caries Res 1992;26:391-396

⁹Shaw L, Smith A. Erosion in children: An increasing clinical problem? Dent Update

1994;21:103-106

¹⁰Bishop K, Kelleher M, Briggs P, Joshi R. Wear now? An update on the etiology of tooth wear. Quintessence Int 1997;28:305-313

¹¹Woodmansey KF. Recognition of bulimia nervosa in dental patients: Implications for dental care providers. Gen Dent 2000; 1: 48-52

¹²Gilmour AG, Beckett HA. The voluntary reflux phenomenon. Br Dent J 1993;175:368-371

¹³RajaRayan R OBE; Changing the Approach to Delivering Dental Education at the London Deanery: report to the Institue of Education 2009

¹⁴The Government's response to the recommendations of the Shipman Inquiry's fifth report and to the recommendations of the Ayling, Neale and Kerr/Haslam Inquiries, Cm 7015 (TSO February 2007)

¹⁵Shipman Inquiry Safeguarding patients: lessons from the past – proposals for the future, Cm 6394 (TSO, December 2004)

¹⁶Ayling Inquiry Independent investigation into how the NHS handled allegations about the conduct of Clifford Ayling, Cm 6298 (TSO, September 2004)

¹⁷Neale Inquiry Independent investigation into how the NHS handled allegations about the conduct of Richard Neale, Cm 6315 (TSO, September 2004)

¹⁸Kerr/Haslam Inquiry Independent investigation into how the NHS handled allegations about the conduct of William Kerr and Michael Haslam, Cm 6640 (TSO, July 2005)

¹⁹Good doctors, safer patients: proposals to strengthen the system to assure and improve the performance of doctors and to protect the safety of patients – a report by the Chief Medical Officer (Department of Health, July 2006)

²⁰The regulation of the non-medical healthcare professions: a review by the Department of Health (Department of Health, July 2006)

²¹The regulation of health professionals in the 21st century – trust, assurance and safety (Department of Health, February 2007)

²²Eccles JD. Tooth surface loss from abrasion, attrition and erosion. Dent Update 1982;9:373-381

²³Eccles JD, Jenkins WG. Dental erosion and diet. J Dent. 1974; 2: 153-159

²⁴Smith BGN, Knight JK. An index for measuring the wear of teeth. Br Dent J 1984;156:435-438

²⁵Bartlett D, A Proposed System for Screening Tooth Wear: Accepted 1st Feb 2010 for publication in the Br Dent J 2010; 2 08:207-209

Failure of Endodontic Treatment

By Sanjeev Bhandari

The foundations of endodontic disease are based quite simply on the balance between microbiological infection and the host's immune response in the periodontal supporting tissues at all the anatomical portals of exit from the pulp space. Success in endodontics therefore depends on reducing the microbiological load inside the pulp space to a clinically insignificant level. In reality, the clinician must perform the treatment adhering to a rigid cross-infection protocol. Failing to do this can adversely affect the success of the case and prognosis of the tooth. In order to maintain endodontic health, it is therefore vital to also prevent re-infection of the pulp space. Mechanisms of failure in endodontics will be outlined in this discussion.

Intraradicular Infection

The most common cause of failure is due to incomplete cleaning of the pulp space.



Figure 1a. Working under magnification

Specific reasons are missed pulp anatomy and poor access.

The concept of cleaning and shaping involves satisfactory preparation and cleansing of the pulp space. Knowledge of pulp anatomy and rectifying previous iatrogenic 'damage' is imperative but often over-looked and certainly requires magnification either with loupes or an operating microscope

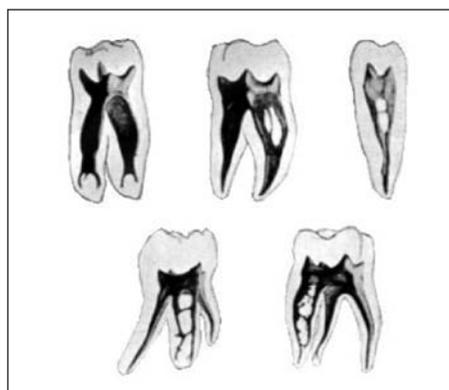


Figure 1b. Myriad of pulp space anatomy (Hess 19252)

(Figure 1a). The root system can be complex (Figure 1b) and anatomy beyond the primary canal space is physically inaccessible to instruments.

Effective access into the pulp anatomy (Figure 2) is a prerequisite for the removal of contaminated coronal pulp tissue and calcifications. Good coronal access allows direct visualization and illumination of the floor of the pulp chamber and that can hinder location and negotiation of the canal orifices.

Decontaminated starts with careful radicular access and a crown-down approach into the canal which in-turn allows progressive chemo-mechanical decontamination towards the hallowed apical constriction (Figure 3). Any breaches in this protocol will compromise success by retaining microflora in the pulp space which could eventually proliferate and lead to a persistent apical periodontitis. Therefore, improvement in the 'straight-line' access is the first stage in re-treating a failed case..

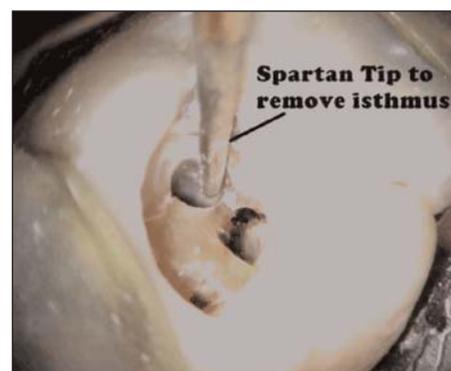


Figure 2. Poor coronal access without removal of pulp chamber roof!

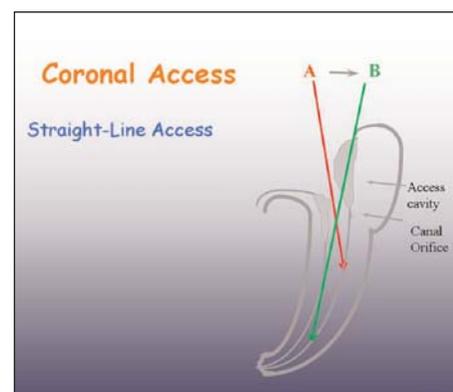


Figure 3. Straight-line coronal access: A -> B

The canal must then be appropriately shaped, respecting the natural root structure, allowing for adequate irrigation flow deeper into the canal space. In addition, an adequate taper is important for the latter stages of treatment as it will enable good introduction and adaptation of the root filling material to achieve satisfactory seal (Figure 4a and 4b).

The ultimate limit of canal preparation is the natural apical constriction; tissue beyond this point is defined as the periodontal ligament³.



Figure 4a(top) and 4b(bottom). Thin root fillings are very indicative of inadequate cleaning and shaping and also poor seal.

Most currently available electronic apex locators (Figure 5) can predictably determine the ideal 'working length' (WL) as 0.5mm from this point (radiographic estimation is 1mm from the anatomical apex based on anatomical averages). It is important then to carefully instrument and widen and debride inside of the apical constriction to allow irrigant to penetrate into this vicinity. Over-instrumentation through the working length will damage the natural constriction and risks extrusion of contaminated debris and microorganisms into the apical tissues, which

may have been uninfected prior to this resulting in failure.

Of course, there are factors that can prevent re-negotiation to the WL: calcifications, ledges, fractured instruments, which can adversely affect success. If these can be successfully negotiated then success rates can be as high as de novo well-treated cases: 84-97% 4, 5.

Extraradicular Infection

Periapical lesions are essentially the host's inflammatory response attempting to restrict the progression of infection deeper into the body tissues. Bone is resorbed and often replaced by granulomatous inflammatory tissues. These lesions are often less vascularised than in health so have a reduced host defence response. In addition, over time increasingly more virulent organisms (e.g. Propionibacterium and Actinomyces spp.) can colonise an apical lesion from the root canal. There is increasing evidence that a biofilm⁵ can develop on the internal and external apical root surface, which is



Figure 5. Current Apex Locators

inherently resistant to host defense mechanisms and intracanal procedures. All these factors can contribute to treatment failure and apical microsurgery may ultimately be the only way to resolve these refractory cases.

Extruded Foreign Bodies

Most of the currently available dental materials are tissue-tolerant and medicaments (i.e. non-phenolic based) are therapeutic, resorbable and tissue reactions are usually short-lived. However, materials used to deliver or hold these medicaments in-between appointments under temporary fillings are not resorbable and can be inadvertently

pushed into the apical tissues (e.g. cotton wool fibres and paper points). Such materials will induce a foreign-body reaction that will compromise apical healing. The use of cotton wool pellets should therefore be replaced with other materials such as sponge pellets (Endo Frost pellets, Roeko). Paper

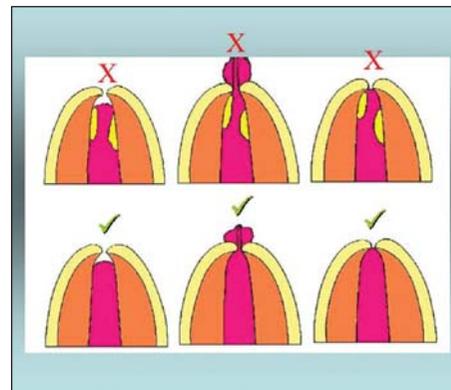


Figure 6. Apical Seal: Top 3 scenarios show poor adaptation and seal. Bottom 3 are all acceptable

points soaked in medicaments should not be used inside root canals as they can disintegrate leaving behind fibres that will be invisible deep inside the canal space and can easily be pushed through the root apex, as well as being a perfect medium upon which bacteria can grow in-between appointments.

Apico- Lateral Seal

Sealing the pulp system after cleaning and shaping is paramount to the success of endodontic treatment for the longer-term. Obturation serves a number of purposes:

- a physical barrier to prevent fluid leakage into the canal space from the coronal and

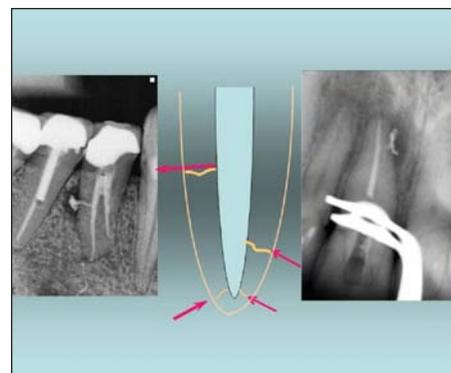


Figure 7 Lateral Seal

periodontal tissues

- entombing infection that is left in the canal space, as it impossible to completely sterilise the pulp system

So, this starts with good apical seal of the

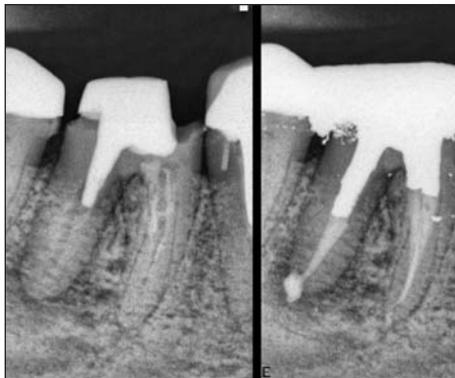


Figure 8 Immediate core restoration securing the coronal seal

root filling material and supplementary sealer (Figure 6).

Current research shows that obturation should ideally be no more than 2mm short of the anatomical³. Some studies have shown reduced success rates with over-filling. This can probably be explained by the fact that an over-extended g.p. master cone may have an inadequate peripheral seal as it protrudes through the apical constriction thus allowing leakage of apical fluids back into the canal and re-activating a lesion⁷. Another explanation is that the apical constriction may have been damaged during preparation and bacteria pushed through, or even carried through during obturation itself, effectively contaminating the apical tissues and causing the failure⁸. Although not ideal, warm gutta percha techniques with modern sealers do sometimes extrude into the apical tissues, but are usually well-tolerated and resorbable over time. Good obturation must extend throughout the pulp system in 3 dimensions (Figure 7). There is ongoing development of non-g.p. based sealers either with the aim of providing a dentine bond (Real Seal1, SybronEndo) inside the root canals or hydrophilic materials that expand and 'tighten' the peripheral seal by absorption of moisture (Smartseal), but further research is still needed to clarify their predictability and performance.

Coronal Seal

It is now accepted that the only source of re-infection post-fill occurs by leakage of oral flora from the coronal aspect of the tooth via a number of ways: recurrent caries, fracture, inadequate marginal seal of the restoration⁹, 10 . It is important to remove all caries and failing restorations to secure the margins of a

tooth before commencing endodontic treatment, otherwise any treatment thereafter will be compromised.

After treatment, securing the coronal seal is the 'icing on the cake' of the obturation phase of treatment as soon as possible (Figure 8). Utilising contemporary dentine and enamel-bonded direct core materials is relatively easy and predictable immediately after obturation, as the tooth is already moisture control with the rubber dam. If appropriate, an indirect cuspal coverage restoration should then be provided to secure the coronal integrity of more broken-down teeth.

In summary, endodontic treatment can be challenging for technical and patient-related reasons. Success rates are very high if treatment is performed with contemporary cross-infection protocol the first time around. Dealing with a failed endodontic case requires careful consideration and planning; the Clinician needs to make the correct choice on whether to take on a failed case or refer to a more experienced colleague. This depends on their skill level, experience, training, and confidence. Any compromise in delivery of care will inevitably result in damaging a tooth's long-term prognosis. This is an unfortunate and avoidable occurrence that is often exploited by certain parts of our profession who advocate extraction of a savable tooth and replacing it with a device that is artificial and non-physiological. Restorative dentistry must always consider endodontics as the first option for tooth preservation; contemporary technology and knowledge has now enhanced the predictability of this treatment modality.

I very much welcome your feedback:
www.endo61.com



Sanjeev Bhanderi

References

1. Schilder H. Dent Clin. North Am. 1974 18:269-296
2. Hess W. New York, NY: William Wood; 1925:3-49
3. Ricucci D, Langeland K. Int. Endo. J. 1998. 31:394-409
4. Farzaneh M, Arbitbol S, Friedman S. J. Endo. 2004. 30:627-33
5. Gorni FGM. & Gagliani MM. J Endo. 2004. 30:1-4
6. Carr GB. Et al. J Endod, 35(9): 1303-9
7. Bergenholtz G. Et al. J. Endo. 1979. 5(10):310-4
8. Siqueira JF. Jr. Int. Endo. J. 2001, 34: 1-10
9. Ray HA & Trope M. Int. Endo. J. 1995 28:12-18
10. Saunders WP. & Saunders EM. Endo. & Dent. Trauma. 1994 10: 108-108

About Me

Sanjeev Bhanderi BDS MSc
 GDC reg. Specialist in Endodontics
 Director of Endo 61 Ltd., a Specialist referral practice in South Manchester, Cheshire
 Senior Lecturer & Course Leader in Endodontology, University of Central Lancs.
 Honorary Lecturer, University of Manchester
 Medico-legal Expert witness (cert. University of Wales, Cardiff Law School)
 Sanjeev is an active postgraduate lecturer teacher and has lectured all over the UK, Europe, the Middle East and Far East.

Intruding anterior teeth in adults

Simple, quick, easy and cost effective treatment for gdp's to explore.

Manny Vasant MBE

Intruding anterior teeth in adults- simple, quick, easy and cost effective treatment for gdp's to explore.

Indications

- 1 to reverse teeth to more optimal position (for example which have migrated due to historical peiriodontal disease-must not be undertaken with active periodontal disease)
- 2 correction of occlusal plane to achieve the desired occlusal scheme
- 3 improve aesthetics



Ortho elastics are available in various lengths

- 4 reestablish lost papillae (eliminate black triangles)
- 5 alternative to extraction (some of these patients were referred for extraction and implants)

Brief technique outline: (may need some training or consultation with an orthodontist if you have no experiance)

- 1 select appropriate anchorage (usually canines to premolars which can be changed if you loose anchorage during rx)
- 2 use appropriate bracket to hold elastics (brackets specified for a tooth and orthodontic elastics can be ordered from The Dental Directory)
- 3 brackets can be cemented with any flowable composite or resin cement.
- 4 use a blob of composite on the tooth being retrolined/intruded more incisal to natural fall of the elastic roughly to equate with the desired movement. This will hold the elastic and create the required active force to intrude tooth.

- 5 elastics (length which determines force. Ranges from ----mm to be changed by the patient every day.

How long does it take?

Approximately 3 to 5 months

What about retention?

Recommend permanent fixed retention 3-3 using multilflex wire. Also nightly use of halwleys retainer (long term for several years if possible)

Case studies illustrated below have been done in the last 3-15 years

Manny Vasant MBE
www.mkvasant.co.uk
GDP and specialist in prosthodontics

MW Treatment stages



Fixed retainer and Hawleys retainer



SS Treatment stages



DK Treatment stages



microminder



DENTAL ELECTRONICS

IT systems
Networking
Digital Imaging
Support & Maintenance
Facial Rejuvenation Technology
Audio Visual Equipment
Telephony

0845 094 1090

www.microminder.com

GETTING IT RIGHT FOR THE FUTURE

UNITED KINGDOM & THE REPUBLIC OF IRELAND

Clearstep™

Case Study 1

Viraj Chopra BDS,MDS,IQE,MSc

Patient A
Male
Age 34yrs

Chief Complaint:
Upper anterior crowding, not concerned about lower anteriors
Treated with Clearstep™ system
Time Scale: 7mths
Pre operative Pictures

Time Scale: 7 months

Pre-operative photographs



7 months Post-operative Photographs



Case Study 2

Raj Bolaky BDS MFGDP(UK)RCS

Patient C
Male
Age 43

Chief Complaint
pt was unhappy with overlapping UR1, UL1 and wanted a simple solution to problem.

Options discussed were:

1. Crowns on UR1, UL1- very destructive and not recommended.
2. Porcelain veneers- will involve some tooth preparation especially on UR1.
3. Orthodontic treatment. Either conventional bracket and wire or 'invisible' braces. Treatment took 8 months to complete.
The UR1 also required mesial and distal composites to improve chipped enamel.

Patient has decided to have orthodontic treatment and has chosen the Clearstep system.

Pre-operative photographs



Post-operative Photograph



Pre-operative photographs



Case Study 3

Patient B
Female
Age 37yrs

Chief Complaint:

Relapsed Orthodontic Treatment with resultant upper and lower anterior crowding. This patient had undergone extensive conventional orthodontic treatment with headgear during her childhood. Her options were discussed and she wanted her teeth to be re-aligned using a clear brace system which did not interfere with her social life and most importantly allowed her to maintain a good oral hygiene.

She was treated with the Clearstep™ system

Time Scale: 22 months

Post-operative Photographs



Although the patient was happy with the results of her treatment she wanted some cosmetic. After cosmetic recontouring



Periodontal Disease as a Risk for Systemic Disease

Manny Vasant MBE BDS MGDS FDS FFGDP Dip Imp Dent- Specialist in Prosthodontics,
Neesha Patel BDS BSc Hons MFGDP M Clin Dent Periodontics
Khalida Ali BDS M Sc Periodontics

(Authors are in clinical practice in London. To download PDF version for your patients: www.mkvasant.co.uk)

Periodontal Disease as a Risk for Systemic Disease

(Summarised from Clinical Periodontology and Implant Dentistry, Lindhe et al, Fifth Edition, Volume 1, 2008)

At the beginning of the twentieth century, medicine and dentistry were searching for reasons to explain why individuals were afflicted with systemic disease. In the absence of much research or insight, two eminent individuals, Willoughby Miller and William Hunter, proposed that oral bacteria and infection were likely causes of most systemic illnesses. Hence, the theory of "Focal Infection" developed and prospered for the next 40 years.

However, by the 1940s and 50s clinicians began to question this philosophy and this led to an era of retreat until about 1989 when it resurfaced with a vengeance.

Literature which has been published since the 1990s suggests that periodontitis (PD) may be a risk factor for certain systemic conditions such as cardiovascular (CV) disease, adverse pregnancy outcomes, diabetes mellitus, and pulmonary disease. Collectively, the findings gathered from investigators worldwide are very compelling. It would appear that PD is strongly associated with systemic conditions.

The field of periodontal medicine addresses the following important questions: Firstly, can bacterial infection of the periodontium have an effect remote from the oral cavity and secondly, is periodontal infection a risk factor for systemic diseases or conditions that affect human health (Carranza, et al, 2006).

Periodontitis as a risk factor for cardiovascular disease

CV disease is the leading cause of death and

morbidity in many developed countries (Humphrey et al, 2008). Many risk factors have been identified, but a significant proportion of CV disease is not explained by traditional risk factors. Recently, several lines of evidence have implicated chronic inflammation aetiologically in CV disease (Ridker et al, 2000). PD is associated with elevations of several markers of chronic inflammation such as C-reactive protein, and thus an aetiological relationship between PD and CV disease has been hypothesized (Noack et al, 2001).

In 1989 Kimmo Mattilla and co-workers conducted a case control study on patients who had suffered from a myocardial infarction. Matilla and co-workers reported a highly significant association between poor dental health and acute myocardial infarction. The association was independent of other risk factors for heart attack such as age, total cholesterol, High Density Lipoprotein(HDL), triglycerides, c-peptide, hypertension, diabetes, and smoking (Matilla et al, 1989).

Scanapieco and colleagues (2003) conducted a systematic review of evidence supporting or refuting any relationship. In response to a focused question, "Does periodontal disease influence the initiation/progression of atherosclerosis and therefore CV disease, stroke and peripheral vascular disease?", they concluded that "PD may be moderately associated with atherosclerosis, infarction and cardiovascular events."

Furthermore, a recent meta-analysis of five prospective cohort studies indicated that both the prevalence and incidence of CV disease are significantly increased in PD (Bahekar et al, 2007).

In addition, a consensus report by the American Academy of Periodontology recommends that: "Patients and health care providers should be informed that periodontal intervention may prevent the onset or progression of atherosclerosis induced diseases"

A responsible clinician should therefore ask: If you treat PD, can you prevent the onset or reduce severity of these systemic complications? Whilst the effects of periodontal therapy on CV disease events have yet to be determined, currently the available data suggest that periodontal

therapies can improve the surrogate cardiovascular outcomes such as biomarkers and endothelial functions.

Biologic Rationale:

Scientists have noted that a patient, for example who has 28 teeth with pocket depths in the range of 6-7mm and associated bone loss, has a large overall surface area of infection and inflammation (Waite and Bradley, 1965). In patients, with moderate PD, the surface area could be as large as the palm of the hand. In addition, the subgingival environment of the periodontal pocket exists in a highly organized biofilm. Since periodontal infections result in low-grade bacteraemias and endotoxaemias in affected patients (Sconyers et al, 1973; Silver et al, 1980), systemic effects on vascular physiology via these exposures appear biologically plausible.

Periodontitis as a risk factor for adverse pregnancy outcomes

In considering adverse pregnancy outcomes, four published intervention studies provide early evidence that preventive and treatment interventions aimed at reducing maternal periodontal infection and inflammation may reduce the likelihood of preterm low birth weight infants, whilst one study did not find such an effect. Overall, these clinical trials suggest that mechanical intervention in pregnant women with gingivitis or PD can reduce the incidence of preterm low birth weight infants.

Pre-eclampsia is a hypertensive disorder that independently contributes to infant morbidity and mortality. Accordingly, atherosclerotic-like changes in placental tissues involving oxidative and inflammatory events, are thought to initiate the development of pre-eclampsia (Ramos et al 1995). A recent systematic review of human evidence suggested that PD is associated with adverse pregnancy outcome. However, it was unclear whether PD played a causal role in those adverse outcomes (Scannapieco et al, 2003).

Periodontitis as a risk for diabetic complications

Similar to cardiovascular disease, diabetes mellitus is a common, multifactorial disease process involving genetic, environmental,

and behavioral risk factors. It is well established through epidemiological research that diabetes increases the risk for and the severity of PD (Papapanou et al, 1996). Furthermore, the weight of current evidence has led to the designation of PD as the "sixth complication of diabetes" (Loe et al, 1993).

In contrast, fewer studies have attempted to examine the effects of PD on diabetic control. Some studies have sought to answer this question using periodontal mechanical treatment as an intervention (Seppala & Ainamo, 1994; Aldridge et al, 1995; Smith et al, 1996; Christgau et al, 1998; Stewart et al, 2001). The results are not equivocal. Some researchers have found an improvement, while others have not. In addition, a longitudinal study of Pima Indians concluded that severe PD was significantly associated with the risk of worsening glycaemic control (HbA1c > 9%) by six-fold over two years (Taylor et al, 1996).

In subjects with severe PD, the death rate from ischaemic heart disease was 2.3 times higher than that of subjects with no or mild PD after accounting for known risk factors. The death rate from diabetic neuropathy was 8.5 times higher in those with severe PD. When deaths from renal and cardiac causes were analysed together, the mortality rate from cardiorenal disease was 3.5 times higher in patients with severe PD (Saremi et al 2005). These findings further suggest that PD is a risk for CV and renal mortality in patients with diabetes (Janket et al, 2003; Scannapieco et al, 2003a; Mealey & Rose, 2005; Saremi, et al; Mealey & Oates, 2006).

At present it is not clear what the effects of treating or reducing periodontal disease in diabetic patients on glycaemic control are. There is however, enough available evidence to at least say that the effect of periodontal treatment on reducing HbA1c levels in diabetic patients has promise. Although there is considerable variability among patients in the studies to date, it is clear that periodontal health is a major goal for subjects with PD.

Periodontitis as a risk for respiratory infections

There is emerging evidence that in certain at risk populations, PD and poor oral health may be associated with several respiratory conditions. Respiratory diseases contribute to

morbidity and mortality in human populations. Lower respiratory tract infections were ranked as the third most common cause of death worldwide in 1990, and chronic obstructive pulmonary disease (COPD) was ranked sixth (Scannapieco, 1999; Scannapieco et al, 2003).

There are a number of studies that examine the effect of treating oral infection in reducing the risk of pneumonia in high-risk populations. DeRiso and colleagues (1996) studied subjects admitted to a surgical intensive care unit. When subjects received a chlorhexidine rinse twice a day, the incidence of pneumonia was reduced by 60% compared to control subjects receiving a placebo rinse. Fourier and colleagues (2000) found a similar 60% reduction in pneumonia with the use of a 0.2 % chlorhexidine gel.

In a landmark study, Yoneyama and co-workers (2002) examined the role of supervised toothbrushing plus povidone-iodine on the incidence of pneumonia in a group of elders living in nursing homes in Japan. When these subjects had their mouths cleaned, with supervision, there was a 39% reduction in pneumonia over a two-year period compared to the control group. Recent reviews of the evidence clearly indicate that when bacterial plaque is reduced in the mouth of at risk subjects, the risk of pneumonia is reduced. The findings are at present limited to populations who are in special-care.

Conclusion

For many years the dental profession has recognised the effects of systemic conditions on the oral cavity. Only now however, are we beginning to understand more fully the influence of the periodontal tissues on systemic health. Although many questions have yet to be answered, the current findings must alert a responsible clinician for a need to keep abreast of new developments in the field. The emerging field of periodontal medicine requires the dental professional to recognise the oral cavity as one of many interrelated organ systems. Thus, the dentist is responsible for controlling the risk factor of periodontal infection by emphasising personal and professional preventive measures focused on thorough oral hygiene and regular recall.

The Private Squat Practice - Myth or Reality?

For the faint-hearted setting up a private squat practice is a challenge. Yet, with goodwill values remaining at all time highs, NHS contracts getting harder to obtain, setting up a private squat practice is potentially the only avenue available for Associate Dentists and Specialists to have their own practice.

But setting up a private squat doesn't have to be a challenge, no doubt it is hard work and not for everyone, but if done right, it can prove to be very rewarding personally and financially.

In the last 6 years I have been personally involved with my wife, Dr Smita Mehra, (a GDP) in setting up 3 private general and specialist dental practices, The Neem Tree, based in London and Surrey (our newest venture is in Esher, Surrey, due to open in Spring 2010). In addition, through my business Samera Ltd, I have been personally involved in many more successful ventures. No doubt, the first practice is where we made most of our mistakes, but since then, we have managed to derive a formula of setting up successful practices clients and ourselves.

The Neem Tree – Esher, Surrey

In our current venture, we have had to deal with many issues that never arose in our Wandsworth of Canary Wharf sites, such as:

1. Dealing with obtaining D1 planning permission and Grade 2 issues with the council
2. Trying to help and house a homeless man living in one of the sheds on the site and liaising with the probation service and police
3. Negotiating with the banks a £1m plus loan in this current economic environment! The list goes on...

As you can see from this short list, none of these issues relate to dentistry (the easy bit!), but plain old common sense and business acumen.

For anyone looking to set up a practice I have

summarized the key factors I personally feel are essential to make a success of a private squat.

1. A Passionate Leader

A leader, passionate about their future business is essential in anyone setting up a private squat. You will need to work with other people, lead them, coach them, even when things hit rock bottom, people will be looking to you for answers.

That's why, before you even decide on setting up a squat practice, ask yourself the question, "Are you truly passionate about making a success of your venture?" No passion, then forget about it.

2. Putting it on Paper

If you feel you have the passion and the gusto, the key is then planning. Clarify your vision and mission, do your research thoroughly, ask for help and then put all your wonderful passionate ideas into a written business plan. Always seek professional help to create your business plan, as this will be the tool that will get you from where you are now (as an Associate), to where you want to reach (a successful private practice owner).

3. Location, location, location

Cliché or not, getting the right location for your venture is an essential component of a successful new private practice.

The hardest thing in any new business is getting customers or patients, so being hidden from your target customer base in terms of location can prove to be commercial suicide.

Always pay a premium for the right location, because if you don't, your future marketing costs will always be high. Short term pain in terms of higher rent usually leads to long term gain as your marketing expenses will be lower, and hence higher profits.

4. Build a team of professionals

We always believe get experts to help you with your business, don't try to cut corners as 9 times out of 10 they will come back to haunt you. So hire a team of accomplished advisors, designers, builders, accountants... who know what they are doing to help you achieve your dream private practice.

Remember, when designing the practice, be different, don't be the same as the practice down the road, dare to be a little risky, as this will get your customers to notice you, even before you open! Get a great designer, don't do it yourself!

5. Raising Cash and Being Tight with The Purse Strings

Armed with a detailed business plan and robust financial forecasts you should start approaching various banks to support the venture.

Sticking to your budget is paramount to getting the business off the ground successfully. Don't be swayed by the salesman!

So is setting up a practice for everyone?

Probably not. It requires stepping out of your comfort zone many a time, working extremely hard, taking decisions that impact not just you but many others too, and basically putting yourself on the line. If you relish that kind of challenge and possess an appetite for calculated risks then you probably need to set up your own orthodontic practice!

Further help

For further help call Samera on 0207 100 8788 or visit our websites, www.settingupinpractice.com and www.samera.co.uk, where our team at Samera would be delighted to help you set up your own dream practice!

Have you got a dead end website? Well, this article is just for you!

How to improve your website and get new patients!

Does your website have a blog and YouTube videos?

A dental website is a 'living and breathing' marketing tool. The world and the web is always changing, advancing and moving forward.

Dental websites can help potential patients develop 'trust' and 'confidence', without even meeting the dentist. The dental clinic is marketing 24/7 through a website. If a practice environment and its technology look outdated, patients will lose confidence in their dentists and start to 'shop around'. Similarly, if a dental practice website looks outdated, visitors will lose trust and move on.

Visitors will not enjoy a web site that is out of date – their attention and interest is key in converting them into patient leads. Returning website visitors will be impressed when they notice new content and activity. A website needs to be a true and current reflection of a dental practice. It should emphasize all the dentist's strengths in a positive and enticing way. That is why we encourage our clients to play a very active role in maintaining and growing their website content i.e. fees, special offers, team updates, treatments and testimonials.

A blog is simply a publishing tool. We visit our clients to empower and train them on how to use blogs and YouTube videos in order to gain control over their website and to add weekly exciting updates, in-house, to their "Special Offers", "Smile Gallery" and "Video Testimonials".

Changes to your website are also necessary for improving Google rankings. Google ranks websites based on relevancy for today. What's deemed relevant for today may not be the same next week or next month. Thus, you need to signal to Google that your website is up-to-date by regular changes to your

website. And Google loves blogs and YouTube videos!

Is your website shouting your Unique Selling Points (USPs) ?

Many dentists regard marketing as a necessity and therefore not always something they need to 'embrace'. For dental marketing to work effectively it needs to be a 'state of mind', it requires a strong, consistent, long-term communication of your Unique Selling Points (USPs).

With all the dental websites out there now, you need to stand out by communicating USPs with specific patients in mind. The website content should be interesting, exciting and worth knowing about and targeting a specific audience.

A dental logo is not a brand. It is only a brand element. To transform your brand is not just about redesigning your logo or the 'look' of your website. A dental brand is about who you are and how you do things – your USPs. A patient may think that they can transform their smile, but we all know that afterwards, behind that smile is essentially the same person.

At Dental Focus Web Design, we help you develop your USPs by emphasizing your strengths i.e. the dentistry expertise, the practice, the people, the treatments and the value you are offering people. The market has become crowded with "me-too" competitors. Unless you just want to compete on price, this is no way forward. You need to differentiate yourself on every single level.

In order to stand out, you have to stand for something. Always beware, of finding yourself saying the same things in the same way as other dentists. It pays dividends to talk not only about your own dental services but also about your own particular dental expertise. In

other words – what makes you different? In fact, we feature on many of our dental websites a page called "Why Choose Us". The most important USPs are about the patient experience – how is the treatment, people, environment and communication different at your dental practice? Make your USPs exciting – learn how to put YouTube videos of patient testimonials on your website every week. Remember, a website is only a reflection of you and your USPs!



Krishan Joshi is "the Master" at Dental Focus Web Design. Follow Krishan on twitter.com/krishanjoshi

Remember to subscribe to our blog by e-mail so you can get all our dental marketing ideas immediately – the Internet Marketing Secrets of "WOW" websites that find you and convert you!"

For free advice on web marketing strategies including website design, blogs and YouTube videos call 020 7183 8388 and visit www.dental-focus.com

Core Fundamentals of a Successful Profitable Practice

By Dr. Rahul Doshi and Dr. Bhavna Doshi

In recessive or regressive economic times, we need to change our focus onto the dynamics of our business. Improvement and mastery of clinical skills is very necessary so that you can provide your dental services to the highest of standards, but it is only half of the equation when it comes to successfully managing your dental businesses. Articulate dental skills do not automatically reflect in the revenues. Therefore, we need to pay more attention to generating Practice Growth and Practice Profits. By implementing both these strategies simultaneously we can safeguard our financial futures.

Hence, in order to maximize and optimize a dental business, all revenue generating sources need to be identified and then these resources need to be leveraged to provide an explosive growth in terms of its revenue generating capacity. Leveraging allows you to gain greater results for the same amount of effort, time and expense. As dentists, we spend most of our time practicing dentistry; therefore, any business activity we do undertake must apply the principal of leverage. This will create the highest and optimal potential of any one situation. There is no room for anything less; otherwise we will get unaffordable substandard results.

For growth and profitability to occur in a dental business, there are certain key areas that need to be worked out. In the same way you assess a patient's mouth and create a treatment plan, you need to assess your practice and create a business plan for profitable growth.

The following is a checklist of Potential Revenue Generating Aspects of Practice:

Master Objectives

It is important you know where you are heading with your business. Every business we have consulted for has a different set of financial and growth objectives. It is important the plan of action you create meets your own personalized goals.

Cash-Flow

The main element which should be at the heart of any business is CASH-FLOW strategy. This is an aspect of business not easily understood but very easily abused. In any business cash is king. Therefore, no business should advance at a rate which is higher than the cash resources that are available. Otherwise success will be short lived because you won't be able to fund any operation. I see this many times when dentists attempt to change the practice philosophy with environmental changes and end up spending a great deal of money on things such as interior design. The practice usually ends up looking beautiful and very innovative. However, these changes are expensive and eat into the cash-flow of a business; especially when there are no strategies in place to ensure and secure higher revenues to meet the new expenses.

Managing your cash-flow in a focused method (with strategy) can be the ultimate difference between success and failure. The five elements that are critical to the survival of any practice at any time and can influence cash-flow are:

1. Type of expense – it must create a return on investment.
2. Vacant spots in the appointment diary – these must be filled.
3. Maintaining a reserve account.
4. Profit Forecasts.
5. Cost-Effective Marketing.

Developing a Unique Selling Proposition (commonly known as USP)

A USP is a unique feature or aspect of your practice that is the reason why patients choose you over and above any other dental practice. This reason should be a prominent feature of any advertising or promotional material you provide.

It will help patients to seek you out because they want what you can provide. All the stakes change when patients want your treatments as oppose to advising them that they should have



your treatment. It becomes a play with demand and supply. If supply (you) is limited and the demand (patients) increases, you will have reign therefore a situation presents itself where your fees can be set at a higher level.

A USP simply says you do a particular thing different to anyone else. Because no one else is saying it, you dominate the market. This in turn allows you to attract pre-qualified, pre-interested patients who are prepared to pay and stay with you.

Target Marketing

This concept simply makes sure that all your marketing efforts are aimed at attracting only those patients that are interested in the type of dentistry you provide. It involves positioning your marketing message in a way that it can be noticed by a significant amount of people, as oppose to spray marketing which is a message directed to anyone who happens to see it. Target marketing allows you to present yourself in a special way.

This in turn, brings in pre-qualified prospective patients that are more likely to say "yes" to your treatment recommendations, because they are interested in the end –result your treatments will provide for them. If more of your patients in any given time say "yes" to your recommendations then you will be producing greater revenues than if less people were to do so. You will be increasing the concentration of responsive patients.

Multi-Generator Approach

This concept allows you to take advantage of multiple activities so that you don't end up having "all your eggs in one basket". This way you will guarantee yourself results. If one method has a bad result, the other activities will hold the fort for you.

The multi-generator approach can be essentially used in two ways:

1. To increase the number of marketing activities you do so that you can have a fair chance at getting a significant amount of appropriate patients for your dental practice. This means that you will be using every single media you can fit into your budget and create appropriate internal systems to get greater case acceptances.
2. To do a multitude of specific marketing campaigns to attract patients interested in

specific treatments. For example, you can do a campaign to attract people interested in teeth whitening at one time and another time focus on attracting people who are interested in obtaining healthy mouths by doing a periodontal marketing campaign.

This method is important because times are constantly changing and therefore to ensure you have covered yourself for the various circumstances that may arise, you need to adopt a multitude of ways of getting your patients to come closer to making that buying decision.

Correct fee setting

The way you charge your fees needs to take into account your overheads and your marketing costs. This is the only way you will be able to create profits.

Overheads should include: practice running costs; the cost to you for bringing that patient into your practice and any supplier/laboratory costs. If you miss out on including your marketing costs, then you will falsely assume that you are creating greater profits when this is actually not true.

For example, if your fee for a crown is £500, but your overheads are approximately 68%, then you will create £160 in profits. On the other hand if your fees are set at £600 with 68% overheads then you will create £192 in profits. The variables are the fee and overhead and they are directly linked.

You will only truly be able to calculate profits by knowing all the vital statistics in your particular practice and situation.

Appointment Diary

This is an extremely useful tool if used correctly. Many dentists are used to seeing an appointment diary as a place to mark when your patients are next coming to see you or to view how your time is going to be spent in any given day. The use of the diary in this way requires no special skill.

However, if the appointment diary was to be converted into a revenue generating machine and engineered so that appointments were only booked in a pre-determined fashion, then you would be applying the principal of leverage. You see, you need to book an appointment anyway, so why not book it in a way that produces an adequate income for you?!

There are many methods you can use to

maximise your appointment diary. One example is that you can divide each day in the appointment diary into 2 or 3 sections. Each of these sections can only hold a certain appointment of a certain monetary value. So you can design each day to make sure that you are generating at least a minimum income.

This way you will not book up one particular day with high revenue generating appointments and yet another day with very low income generating appointments.

Creating an internal process for the way you manage patients

If you want to increase your chances of creating greater revenues then you need to create a process of how your patients are going to “journey” through your practice. So, how will they be managed when they first arrive, then what happens to them, etc. You need to work out an exact sequence of the process leading to patients finally accepting your recommendations and going ahead with the treatment. Often the process need not end here. You can make the process as extravagant or as simplified as you want. The ultimate aim is to gain case acceptances. Therefore, it is a sales process in kind.

For this reason, the entire process needs to be designed to bring the patient closer to a favourable buying decision. The steps in the process should at the very least contain the following:

1. An evaluation of patients wants and needs. Understanding character types and why they want the treatment.
2. Relationship building.
3. A detailed analysis of their current situation via a co-discovery process.
4. Presenting your case and all the possible options.
5. Overcoming any objections.
6. Providing treatment in an affordable manner.
7. Setting up an internal referral system.

Co-diagnosis

Gone are the days when the survival of your practice was dependent solely upon your advice alone. Even if you have the best of intentions your patients will only accept in their minds what they fully understand.

For this reason, any assessment of any mouth needs to be a co-discovery process as oppose to the dentist doing the clinical examination, then telling the patient what they need to have done.

Detailed explanation and use of props at the

time of assessment will greatly increase the chances of getting case acceptances. It is a way of preparing the patients for your advice. This way when it comes to discussing the way forward, patients often are the ones eager to have the correct treatment done.

Complimentary customer service

In today's unpredictable market environment, customer service should be exquisite. This should occur as a matter of protocol in your practice and not just an occasional event. The entire industry is evolving into a state where professional services cannot be supplied in any other way than with utmost care and consideration. Anything you can do to enhance the delivery of your treatment will add to the value that patients perceive they are getting from your practice. Your treatment fees then become value for money. Therefore even if your fees are slightly higher than normal, patients will perceive them to be value for money, however, presenting high treatment fees with no additional value-add will cause patients to seek value elsewhere.

Complimentary customer service becomes that extra seal stating to the patients “you made the right decision having your dentistry with us”.

A good place to look at to borrow ideas from is the hotel, holiday resort and restaurant industries. They have worked hard to make customer service a notable feature and we can learn a great deal from them.

Summary

As it can be seen increasing revenues is not just about seeing more patients but instead it is about providing quality treatments that are perceived to be value for money. It is about approaching dentistry with a business mindset to maximize by leveraging your potential assets.

By understanding all the different variables present within a practice you can use them as tools to increase your bottom line figures.

Drs. Rahul & Bhavna Doshi are directors at The Perfect Smile Studios and founders of Dental WEALTH Builder. They are International Speakers and Coaching Consultants to many businesses providing help in areas of Practice Profit Solutions, Team Management & Motivation, Business Strategy, Cost-Effective Marketing, Sales Process Strategy and Wealth Creation.

If you have enjoyed the above article and would like to receive a FREE E-Course on Business Marketing & Profit Strategy, then please go to www.dentalwealthbuilder.com

HTM 01-05: Decontamination in primary care dental practices. The facts at your fingertips

By Mo Tabeoadbar and Lorena Bega (Architectural Technologists specialising in Dental Practices)

Health Technical Memoranda (HTMs) give comprehensive advice and guidance on design, installation and operation of specialized building and engineering technology used in delivering health care. They are applicable to new and existing sites, and are for use at various stages during the whole building life cycle.

Healthcare providers (both in NHS and Private sector) have a duty of care to ensure that appropriate governance arrangements are in place and are managed effectively. Amongst the nine core subjects the HTM 01 (Decontamination) updated in April 2009 (01-05 version) is currently a hot topic for dental practices throughout the UK. Full document can be downloaded on www.dh.gov.uk/publications. Hard copies of this document were sent during the autumn of 2009 to each practice. The essential elements for dental practitioners in the UK are as follows:

Over the next two years, the registration of healthcare providers, including dental practices both working within the NHS and entirely privately, will be introduced. The care quality commission (CQC) will oversee this process and have a regulatory responsibility to ensure that the requirements for registration are met. This includes provision of safe, clean environment and appropriate decontamination of dental equipment.

“Essential quality requirements” (every practice should be capable of meeting the essential quality requirements within 12 months of publication of this document)

- Regardless of the technology used, the cleaned instruments, prior to sterilization, should be free of visible contaminants when inspected. Instruments should be reprocessed using a validated decontamination cycle including: cleaning/washing (in terms of manual cleaning, this includes having a written protocol); a validated steam sterilizer, and at the end of the reprocessing cycle they should be in a sterilized state.
- Reprocessed dental instruments should be stored in such a way as to ensure restraint of microbiological recolonisation. These measures should be backed by careful controls on the storage times to which instruments that are less frequently used are subject.

- Practices should audit their decontamination processes quarterly using an audit tool (the use of the Infection Prevention Society/DH audit tool that accompanies this document is strongly recommended).
- Practices should have in place a detailed plan on how the provision of decontamination services will move towards best practice.

“Progression towards best practice” (no time scale stipulated for this although plans must be made), further improvements are required in three main areas:

- A cleaning process that should be carried out using a validated automated washer-disinfector.
 - The environment in which decontamination is carried out should be such as to minimise the risk of recontamination of instruments and the possibility of generating aerosols, which may reach patients or unprotected staff. For best practice, the decontamination facilities should be clearly separate from the clinical treatment area. This implies the use of a separate room or rooms for the accommodation of clean (output) and dirty (input) work. In these facilities, the room(s) should be used for this purpose only and access should be restricted to those staff performing decontamination duties. However, plant and equipment not necessarily used for The 2009 revisions to the HCAI Code of Practice make specific reference to this Health Technical Memorandum. However, these Health Technical Memorandum criteria themselves do not form part of the Code at this time, nor are they currently part of ‘Standards for Better Health’.
- 3Decontamination: Health Technical Memorandum 01-05 – Decontamination in primary care dental practices
- For best practice, the clinical treatment area should be clearly separate from the decontamination facilities
- decontamination may be located in these rooms (but preferably in the dirty room) provided it can reasonably be shown that the devices do not conflict with the requirement for a clean environment.
- The storage of reprocessed dental instruments in a simple but carefully designed facility clearly separate from the clinical treatment area is an important best practice improvement. The facility should take account of the need to reduce recolonisation of

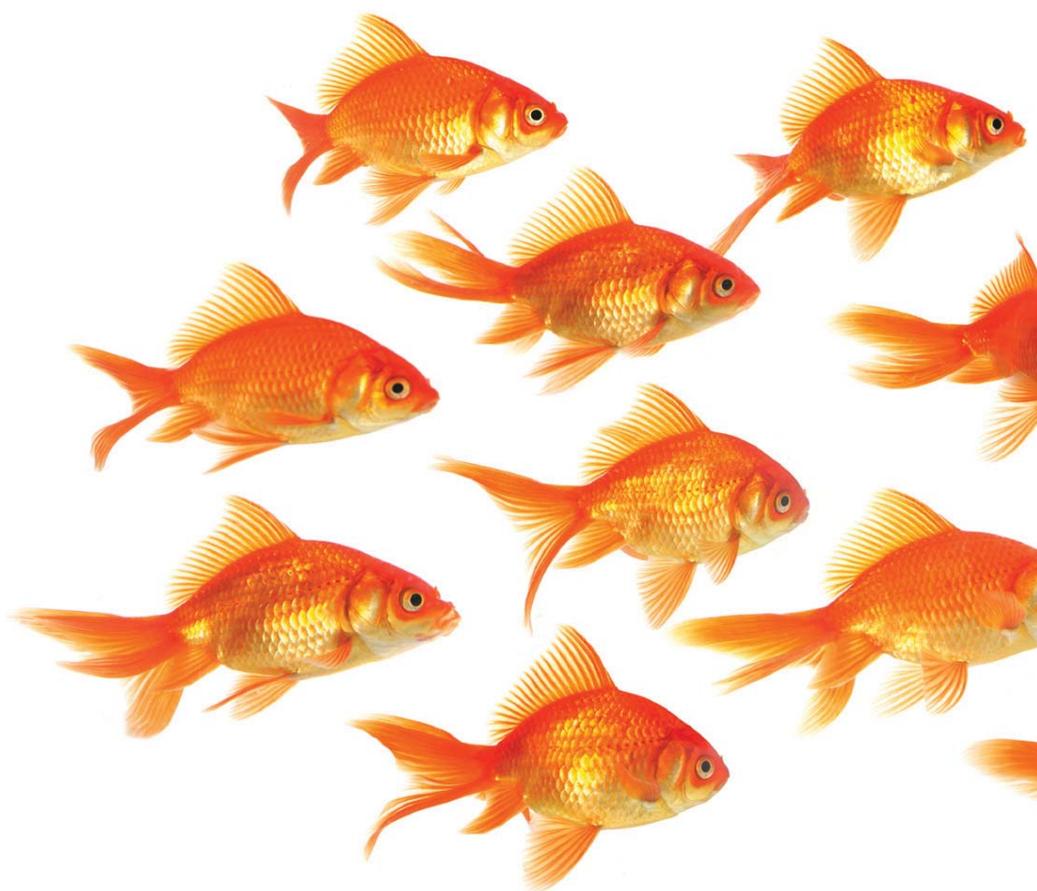
sterilized instruments and also make the identification/selection of instruments easy. This storage facility will ordinarily be part of the clean area within the decontamination room(s).

Images supplied by Pars Dental.



New ideas

Bringing you the world's leading thinkers in
aesthetic and restorative dentistry to share their
experience and knowledge in the heart of the capital.



The Clinical Innovations Conference 2011

Friday 6th and Saturday 7th May 2011

The Royal College of Physicians, Regent's Park, London

For early bird offers go to

www.clinicalinnovations.co.uk

or call 020 7400 8967



For Consumables,
Equipment, Oral Hygiene,
Orthodontics,
Surgical Accessories,
Facial Aesthetics,
and so much more...

Trust The Dental Directory

The Dental Directory is your one-stop-shop for all your dental supplies. Stocking over 26,000 product lines – all with free next day delivery – you can be sure to meet the demands of your patients and practice.

Our network of highly trained Business Consultants are available to offer help and advice on all the latest products and innovations and also have access to a range of cost reduction programmes designed to save your practice time and money.

For further information on how The Dental Directory can help you, or to place an order, call FREE on

0800 585 586

or visit www.dental-directory.co.uk

Great Benefits for all AOG Members

A 15% discount off branded products in the current Dental Directory Master Product Guide.

15% discount off Master Product Guide prices on our house preferred product ranges.

An additional 1.5% discount off all products when ordered via the internet on www.dental-directory.co.uk or The Desktop Directory computer ordering system.

Trust...



to give you more